QUESTIONS AND ANSWERS FROM PSBI COP WEBINAR

10-25-18

RESPONSES BY DRS. TESHOME DESTA AND IRIYA NEMES WHO/AFRO AND TANZANIA

Distance learning

QUESTION: HOW LONG IS THE DISTANT LEARNING APPROACH AND WHAT ARE THE COST IMPLICATIONS?

Depends on the context and the amount of modules. For Tanzania, after the last adaptation the duration was increased to 10 weeks, with three face to face sessions and two self-learning phases. The two self-learning phases are each 5 weeks long. Phase 1 covers 10 modules- General danger signs – to HIV, while Phase 2 covers Newborn, Supply Chain Management and Well Child. The training uses parallel training method where several training sites are identified; each site conducting consecutive 2- 3 daily sessions depending on the number of targeted health workers in a district. The aim is to cover up to 90% of eligible health workers in one training course.

QUESTION: HAS THE EXPERIENCE OF DISTANCE LEARNING BEEN PUBLISHED?

Yes. The publication for lessons learnt was published- Muhe et al. BMC Health Services Research (2018) 18:

QUESTION: HOW WAS THE EFFECTIVENESS OF THE DISTANCE IMNCI TRAINING?

Effectiveness was not measured, however lessons learned showed potential for rapid scale.

QUESTION: CAN YOU REFLECT ON BARRIERS TO ADAPTING DISTANCE LEARNING FOR OTHER COUNTRIES - COSTS, TECHNOLOGY, COMPLEXITY, INERTIA?

The cost is much less than standard and the coverage is faster within the short period

THE DISTRIBUTION OF HEALTH FACILITIES AND AVAILABLE HUMAN RESOURCE CAN INFLUENCE THE WAY DIMCI IS IMPLEMENTED.

Countries need to review the health system and decide on the modalities of implementation. Implementation strongly depends on the country context.

The dependency on per diem- based training can cause initial inertia

Policy makers need to be well convinced before undertaking. Bench matching is useful to convince.

QUESTION: HOW DO WE ENSURE QUALITY ASSURANCE WITH DISTANCE LEARNING GOING FORWARD?

Using same principles as the standard training.

Build a strong TOT base and local facilitators to ensure mentorship.

Supervision and mentorship using several strategies, mobile and physical visit during self-learning and after training.

Establish facility based mentorship in large facilities with many health workers, eg a busy health center

QUESTION: ONLY PAKISTAN MENTIONED QI TEAMS AND TEDBABE MENTIONED ADHERENCE TO GUIDELINES BUT HOW DO WE ACTUALLY TRACK HW BEHAVIOR OVER TIME POST DISTANCE LEARNING TRAINING OR OTHER TRAINING?

Follow up after training is conducted 6-8 weeks and later quarterly depend on the availability of resources.

Ensure the district facilitator/s is are part of routine supervision.

When there is new technical recommendation, use opportunity to refresh whole IMCI since it requires no additional resources.

QUESTION: DOES WHO AFRO HAVE PLANS FOR PROMOTING DISTANCE LEARNING IMCI REGIONALLY?

AFRO supported Eswatini and Zimbabwe to introduce and complete the first cohort of dIMNCI learning health workers with 98% completion in Zimbabwe in two districts and about 80% completion in Eswatini. Uganda has been doing an implementation research with a simple interrupted version compared to a standard d –IMNCI learning 4 districts (2 districts for each model). Uganda was planning for proper evaluation but not sure if they have done it.

PSBI in pre-service training

QUESTION: IS THERE ANY PROGRESS IN INCORPORATING PSBI INTO PRE-SERVCIE TRAINING CURRICULUMS? IF YES CAN YOU SHARE EXPERIENCES.

Some countries have included PSBI into IMNCI using ICATT to train health workers including preservice. We can follow up with the countries and feedback later.

PSBI implementation without IMCI

QUESTION: IS THERE, BY ANY MEANS, OPTIONS WHERE PSBIS COULD BE IMPLEMENTED WITHOUT IMCI?

No, I am not aware of any country doing this option.

QUESTION: JUST FOR CLARIFICATION, ARE COUNTRIES IMPLEMENTING PSBI INTEGRATED WITH IMNCI/ICCM OR AS A FOCUS INTERVENTION FOR NEWBORN SURVIVAL?

Yes, countries have integrated PSBI with IMNCI and community based Newbron care and ICCM.

RESPONSES BY DR. SHABINA ARIFF/PAKISTAN

QUESTION: WHAT IS THE LEVEL OF TRAINING OF LHWS IN PAKISTAN. ARE THEY THE SAME AS CHWS IN THE SUB-SAHARAN CONTEXT?

The LHW have grade 8 education b/w ages of 18 to 45. Following recruitment, they receive 15 months training which is class room and field work including training at Basc health unit.

Yes, you can call them to CHW equivalent

QUESTION: CAN YOU PLEASE SAY SOMETHING REGARDING TREATMENT COMPLIANCE ON THE PSBI INTERVENTION IN PAKISTANI? WAS TREATMENT COMPLIANCE MEASURED?

Compliance was generally good with oral antibiotic and for the first dose injectable antibiotics. Yes, it was measured

QUESTION: HOW DID THE PAKISTAN PROGRAM TACKLE THE BELIEFS AND SOCIAL BARRIERS?

Community mobilization through LHW. Health education sessions were done to create awareness among community on danger signs and the need to seek care.

QUESTION: PAKISTAN - LIKE OTHER SOUTH ASIAN COUNTRIES -- HAS A VERY LARGE PRIVATE SECTOR (OFTEN UNQUALIFIED PROVIDERS). DO YOU KNOW THE PREVALENCE OF CARE SEEKING FROM AND THE ROLES OF THESE PRIVATE PROVIDERS IN RURAL SINDH AND PUNJAB?

Throughout Pakistan it is almost 50% private sector

QUESTION: WHAT IS THE DENOMINATOR OF THE INDICATOR, WAS IT TOTAL SICK INFANTS OR THE NUMBER OF SICK INFANTS VISITED BHU?

Number of sick infants that visited BHU with PSBI

QUESTION: WHAT IS THE TREATMENT COMPLIANCE PERCENTAGE OF THOSE 85% , TREATED IN BHU?

Will have to check from data

QUESTION: WHY DID 85% REFUSE HOSPITAL ADMISSION AND TREATMENT AT BHU?

Reasons are multifactorial:

1. Accessibility
2. Lack of trust /faith in the hospital staff
3. No finances
4. Govt sector hospitals do not deliver care

QUESTION: IS THAT NORMAL CARE SEEKING PATTERN OF THE COMMUNITY THAT THEY DO NOT PREFER HOSPITAL VISIT AND ADMISSION?

Yes

QUESTION: 85% REFUSAL FOR REFERRAL IS VERY HIGH - DO WE KNOW WHY PARENTS REFUSE REFERRAL? IS THERE A NEED TO ADDRESS THIS?

Yes.

The government is working to improve the service delivery at all levels of health care provision.

Over last 2 to 3 years the PPHI which is a private company is in charge of BHU and has brought significant improvement in provision of services at Basic Health Unit.

More facilities at a higher level are now being upgraded with staff and equipment.

But still a considerable community based awareness, prevention and promotion of health at grassroot level is needed.

RESPONSES BY DR. TEDBAB/UNICEF

QUESTION: FOR INDONESIA IMPLEMENTING PSBI IN PROVINCES AND DISTRICTS - ARE THEY INTERESTED IN TARGETING HARD TO REACH/REFER POCKETS? IS THIS COST EFFICIENT? DO THEY PLAN TO IMPLEMENT ALL OVER INDONESIA OR JUST ISOLATED AREAS?

The targeted provinces are hard to reach that have below national average performance on many of newborn health indicators.

QUESTION/COMMENT: A LITTLE EXPLANATION ON HOW TO IMPLEMENT THE 17 IMNCI MODULES IN INDONESIA USING THE OJT APPROACH WILL BE USEFUL.

On-the-job training (OJT) is same as the regular IMCI in-service training but with the difference that is given in health facility where the health workers(both facilitators and trainees) work. Competency will be assessed in pre/post test, skill assessment using the IMCI checklist. This method offers two advantages: much reduced cost plus not taking health workers away from their duty station. Completing the OJT has a credit hour that will be useful for acer advancement.

QUESTION: YOU MENTIONED WHO VIDEOS BEING USED IN TRAINING. COULD YOU CLARIFY WHERE THESE VIDEOS CAN BE OBTAINED? ARE THESE THE TRAINING VIDEOS DEVELOPED BY GLOBAL HEALTH MEDIA PROJECT?

Tanzania and Niger used the global health media video. Indonesia used the old WHO videos